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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 11 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 30860

Registration District No. 399 — Primary Registration District No. 1002 — Registrar's No. 3423

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: K.C. General Hospital No. 1, K.C., Mo.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 days (Specify whether years, months or days)

In this community same

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town Osceola
(If outside city or town limits write "RURAL")

(d) Street No. 0
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME DIXIE FAULKNER

3. (b) If veteran, name war ---

3. (c) Social Security No. --

4. Sex F M.

5. Color or race W.

6. (a) Single, widowed, married, divorced S.

6. (b) Name of husband or wife --

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Not given (Month) (Day) (Year)

8. AGE: Years 7 | Months -- | Days -- | If less than one day hr. min.

9. Birthplace Not given (City, town, or county) (State or foreign country) S

10. Usual occupation Schoolbody S

11. Industry or business ✓ S

FATHER
12. Name Jim Faulkner
13. Birthplace Not given (City, town, or county) (State or foreign country) ✓

MOTHER
14. Maiden name Not given
15. Birthplace Not given (City, town, or county) (State or foreign country)

16. (a) Informant Jim Faulkner
(b) Address Osceola, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-3-40 (Month) (Day) (Year)
(c) Place: burial or cremation Osceola, Mo.

18. (a) Signature of funeral director [signature]
(b) Address [signature] Osceola Mo.

19. (a) Sept. 1, 1940 (Date received local registrar) (b) M. M. Grove (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 1st year 1940 hour 6:15 minute A. M.

21. I hereby certify that I attended the deceased from 8-29-40 [illegible], 19__, to 9-1-40, 19__; that I last saw her alive on 9-1-40, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Acute anterior poliomyelitis	
Due to 16	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy None	

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? 361 (Specify type of place)

While at work? (e) Means of injury 1

23. Signature [signature] (M. D. or other)

Address Med. Dir. K. C. Gen. Hospital Date signed

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.